Client Name: _____

The Center for Creative Arts & Play Therapy, LLC

Office Policy Statement

Welcome, and thank you for choosing the Center for Creative Arts and Play Therapy. Our desire is to provide professional counseling services to children, adolescents and adults. Please carefully read the following information regarding the office policies. Your signature will indicate consent for treatment and an understanding of our office policies and procedures.

APPOINTMENTS

Appointments can be made by contacting your therapist directly at the number he/she provides. Additionally, appointments can be made by calling the office on Tuesdays and Thursdays between 9AM and 3PM at (717) 741-0000, or by scheduling before or after your appointment with our office manager. It is our practice to schedule appointments in advance to provide you with consistency and the most convenient appointment times for your schedule. Please understand that early morning and evening appointments are on high demand and you may have to be patient in receiving those time slots. We will gladly alert you of any cancellations should you be interested. However, it may be necessary for children to leave school for professional appointments and if this is necessary, we will provide an excuse slip as documentation of the appointment. _____

CANCELLATIONS AND MISSED APPOINTMENTS

When scheduling an appointment, that time slot is reserved for you. If you must cancel it is our policy that you must provide at least 24 hours' notice. A cancellation received less than 24 hours prior to the scheduled appointment will result in a charge of $70.00. Failure to show up at an appointment will also result in a charge of $70.00. Insurance companies will not reimburse for missed or cancelled appointments. Payment must be received on or before the next scheduled appointment.

After 2 cancellations without notice, service may be terminated and referral information will be provided. This policy excludes a serious medical emergency or illness, natural disaster, accident and extreme weather conditions. Business meetings, exams, sporting events and minor illness, (i.e. Common cold) do not qualify as an excused session. _____

EMERGENCIES

For life threatening emergencies call 911, proceed to your local emergency room, or call crisis intervention at (717) 632-4900. _____

CONFIDENTIALITY

Information provided during therapy sessions is held in the strictest of confidence. Case notes will not be provided to a third party without written authorization from you. However, there are limits to confidentiality. These limits include:

1. Duty to warn and protect. When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
2. Abuse of children and vulnerable adults. When there is suspicion of abuse or neglect of a child, elderly person or disabled person, the mental health professional is required to report this information to the appropriate social service and/or legal authority.
3. Prenatal exposure to controlled substances. Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
4. When a court order exists to release information.

I understand that I am granting permission for my therapist to collaborate with other licensed therapists on staff here at The Center for Creative Arts and Play Therapy regarding my/my child's/my family's case and treatment plan.

For parents of minors, please understand that therapy being provided is not for custody purposes or disputes. Therefore, you knowingly and freely wave your right to request the release of information to your attorney or any other officer of the court *for custody purposes.* _____

MINORS & PARENTS

Patients under the age of 18 who are not emancipated from their parents should be aware that the law may allow parents to review their child's treatment records. Due to privacy in psychotherapy being essential to successful progress, especially with teenagers, it is at times my policy to request an agreement from parents that they provide consent to waive access to their child's records. If agreed, at scheduled appointments parents will only be provided with general information regarding the progress of the child's treatment. A summary of the child's treatment will also be provided at the conclusion of treatment. Any other communication will require the child's consent, unless I feel the child is in danger or is a danger to someone else, in which case I will immediately notify the parent. Prior to communicating any information with parents, I will discuss the matter with the child and handle any objections as appropriate.

FEES

All services are billed at a per session rate. A regular session is 45-minutes. All co-payments, co-insurance payments or private payments are due at the time of services. The currents fee schedule is as follows:

Initial assessment	$150.00	Family therapy	$110.00
Individual therapy	$105.00	70-80 min. session	$154.00
OT Evaluation	$150.00	OT Treatment per 15 minutes	$40.00
Group therapy	$40.00/person		
Missed appointment	$70.00		
Late cancellation fee	$70.00		

BILLING AND FINANCIAL RESPONSIBILITY

For health insurance holders: The Center for Creative Arts and Play Therapy participates with a number of insurance providers. Please contact your insurance carrier prior to you first appointment to verify the following information:

1. Is the Center for Creative Arts and Play Therapy a participating in-network provider?
2. Does my insurance policy provide mental health benefits?
3. Do I have a deductible?
4. Do I have a co-pay or co-insurance?
5. Do I have a minimum number of sessions?
6. Do I need pre-authorization for services?
7. What is the billing address?

Please be able to provide this information to the office manager prior to your first appointment. If your insurance requires a pre-authorization please bring the authorization number with you to your first appointment.

Co-payment is expected at the time of service. We will bill your provided healthcare insurance company and follow the contractual obligations that exist between your healthcare insurance company and our center. Our office will only file an insurance claim if our office is a participating provider. Otherwise, it will be your responsibility to seek reimbursement from your insurance company, and you will be responsible for payment in full to the Center for Creative Arts and Play Therapy. You have a responsibility to be aware and understand the provisions of your healthcare insurance policy. Please remember that insurance and behavioral health plans are a method of reimbursement for services, and not a substitute or guarantee of payment.

Please understand that insurance is a contract between you and your insurance carrier. Therefore, in the event that your insurance company does not reimburse for services rendered as anticipated, you will be responsible for all incurred fees and expenses and will be billed accordingly.

For self-pay clients, or those with non-participating or out-of-network plans, full payment is expected at the time of service. Our office will be glad to provide you with an invoice to potentially obtain reimbursement. _____

PAYMENTS

Payment for services may be made by cash, check, or credit card (including those credit cards for HSA/FSA purposes). We do not accept debit cards. Please make all checks payable to Betsy Craft or the Center for Creative Arts and Play Therapy, and provide payment to the office manager before your session starts. If the office manager is not on site, please have your check written ahead of time so that your full session time can be designated for therapy. Please make every attempt to have exact amount for cash payments. Change may not be able to be provided. Returned checks will result in a charge of $35.00 to cover bank charges and processing fees. Again, all payments are expected at the time of service. If you do not have your payment on the date of service, we reserve the right to reschedule your appointment. _____

****

Please initial at the end of each section acknowledging that you have read and understand each individual section and policy. Please do not hesitate to ask any questions for clarification on any of the information. Please sign and date at the provided space below; please understand that by signing below you fully acknowledge receiving and understanding the office policies as stated. Any update or change to these policies will be provided to you in writing.

Client name: _____ Date:_____
Responsible party: _____
Relationship to client: self parent spouse legal guardian
Home Address:
_____
_____
Home Phone: (___) _____-_____
Cell Phone: (___) _____-_____
Work/Alternative Phone: (___) _____-_____
Email address_____

Your signature indicates consent for treatment for you and/or your child as well as an understanding of our office policies and procedures.

Signature of responsible party: _____